DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/18/16

PRINTED: 08/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445460	A. BUILDING _____ B. WING _____	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCO MANOR NURSING AND REHABILITATION CENTER, INC	813 S DICKERSON RD GOODLETTSVILLE, TN 37072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 11 Medical record review of Resident #209's comprehensive assessment MDS dated 7/25/16 revealed the resident scored 12 out of 15 on the BIMS, indicating the resident was independent with daily decision making. Medical record review of the eMAR dated August 2016, with the Physician's Order dated 7/31/2016, revealed "...Nexium [medication to block stomach acid secretion] Delayed-Release 40 mg [milligram] [1] Susp [suspension] for Recon [reconstitution] Delayed Rel. [release] in a packet Oral Every One Day Starting 08/01/2016 ..." Continued review revealed the facility documented giving Resident #209 the Nexium medication on 8/1/16 and 8/3/16. Continued review revealed the medication was documented as not available on 8/2/16. Interview with Resident #209 on 8/4/16 at 9:50 AM, in the resident's room confirmed "...they gave me Mylanta [medication to neutralize stomach acid] again today...nurse...told me today they don't have my medicine...they keep giving me Mylanta and it doesn't help...I have not had my Nexium since I have been admitted here..." Interview with LPN #4 on 8/4/16 at 4:28 PM, in the 300 hallway confirmed "...I did not give her Nexium today...it's not here...we would never have received any Nexium from the pharmacy because they never had an order..." Telephone interview with RN #4 on 8/4/16 at 6:53 PM, in the conference room confirmed "...I didn't give the resident any Nexium [8/1/16]...I just charted it but I didn't give it..."	F 514	K 021: Corrective Actions: 1. A. The lower latching locking hardware was repaired on 8/1/16. B. The paint from a and b doors had the fire rating labels cleaned of all paint on 8/15/16. C. The doors are being replaced, the order was completed on 8/8/16. D. The door is being replaced and was ordered on 8/8/16. 2. A. An audit was completed on all doors with the same latching mechanism to ensure proper function. B. All doors have been audited for obstructing paint on the labels. C. 100% audit of all fire doors to ensure they have appreciate labels has been completed and doors ordered where necessary.	

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F 514	Continued From page 12 Interview with the Director of Nursing (DON) on 8/4/16 at 5:34 PM, in the lobby confirmed Allopurinol was not available for administration but had been documented as administered. Continued interview with the DON at 6:16 PM, in the DON's office, confirmed according to the nursing staff interviews, the medication had been inaccurately documented as administered.	F 514	K 021: D. All doors with locking hardware have been checked to ensure they are functioning properly. Any deficient locks have been ordered or replaced. 3. The maintenace supervisor was re-educated on the regulation and to ensure placement for all fire rating labels on 8/15/16, and to follow behind any painting contractors to ensure that this regulation is met. He was also re-educated repairing locking hardware timely to ensure doors are locked and functioning properly. 4. The maintenance director will audit behind all contractors or any projects that could result in this deficiency to ensure compliance with this regulation. His monthly findings will be brought to the QA meetings for trending and necessary follow up. Daily QA rounds will immediately address any concerns found.	9/15/16

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	445460	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCO MANOR NURSING AND REHABILITATION CENTER, INC	813 S DICKERSON RD GOODLETTSVILLE, TN 37072

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K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to maintain the cross corridor fire/smoke doors. The findings included: 1. Observation on 8/1/16 at 11:20 AM, revealed the lower latching hardware installed on the fire doors located near room 113 were not working properly. NFPA 101, 4.4.2.1 (2000 Edition), NFPA 101, 8.2.3.2.1 (2000 Edition), NFPA 80, 15-1.2 (1999 Edition). 2. Observations on 8/1/16 at 11:21 AM, revealed the fire rating labels were painted over on the following fire/smoke doors.	K 021		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 8/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 021	Continued From page 1 a. Near room 113 b. Near ADON Office at 11:30 AM. NFPA 101, 4.4.2.1 (2000 Edition), NFPA 101, 8.2.3.2.1 (2000 Edition), NFPA 80, 10-2.4.1 (1999 Edition). 3. Observation on 8/1/16 at 11:30 AM, revealed one (1) of the cross corridor fire doors located near the ADON Office was missing the fire rating label. NFPA 101, 4.4.2.1 (2000 Edition), NFPA 101, 8.2.3.2.1 (2000 Edition), NFPA 80, 1-5 (1999 Edition). 4. Observation on 8/1/16 at 11:52 AM, revealed the Maintenance Office fire door facing was damaged near the locking hardware. NFPA 101, 44.2.1 (2000 Edition), NFPA 101, 8.2.3.2.1 (2000 Edition). These findings were verified by the director of maintenance and acknowledged by the administrator during the exit conference on 8/1/16.	K 021		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the smoke barrier walls. The finding included:	K 025		

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	445460	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/01/2016

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K 025	Continued From page 2 Observation on 8/1/16 at 10:52 AM, revealed one penetration of three (3) low voltage data cables in the the fire/smoke barrier wall by the admissions office. National Fire Protection Association (NFPA) 101, 4.4.2.1 (2000 Edition), NFPA 101, 8.2.3.2.4.2 (2000 Edition). This finding was verified by the director of maintenance and acknowledged by the administrator during the exit conference on 8/1/2016.	K 025		

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Division of Health Care Facilities

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	TN1929	A. BUILDING: _____ B. WING _____	08/04/2016

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VANCO MANOR NURSING AND REHABILITATI	813 S DICKERSON RD GOODLETTSVILLE, TN 37072

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N 000	Initial Comments During the annual licensure survey conducted on 8/1/16-8/4/16 at Vanco Manor Nursing and Rehabilitation Center, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	K 025: Corrective Actions: 1. The penetration was filled with "Fire Stopper 5000 Flexible Intumescent Sealant Item#: 3629-5-61" UL1479/ASTME814 See attached system. 2. An audit was completed on all firewall and penetrations requiring fire sealant to ensure proper sealing per this regulation as of 8/17/16. 3. The maintenance supervisor was re-educated on the regulation on 8/15/16, and to follow behind any contractors to ensure that this regulation remains met. 4. The maintenance director will audit behind all contractors or any projects that could result in this deficiency to ensure compliance with this regulation. His monthly findings will be brought to the QA meeting for trending and any necessary follow up. Daily QA rounds will also immediately address any issues that are found.	9/15/16

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 8/19/16

STATE FORM 6899 B9JO11 If continuation sheet 1 of 1